St. Bartholomew's Hospital

"Æquam memento rebus in arduis
Servare mentem."
—*Horace*. Book ii, Ode iii.

JOURNAL.

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CALENDAR.

Mon.,	April	13.—**Easter Monday.**
Tues.,	,,	14.—Dr. Graham and Mr. Girling Ball on duty. Rugby Match *v.* Bristol. Away.
Fri.,	,,	17.—Dr. Geoffrey Evans and Mr. Roberts on duty.
Tues.,	,,	21.—Prof. Witts and Prof. Paterson Ross on duty.
Thurs.,	,,	23.—**Last day for receiving matter for the May issue of the Journal.**
Fri.,	,,	24.—Dr. Hinds Howell and Sir Charles Gordon-Watson on duty.
Tues.,	,,	28.—Dr. Gow and Mr. Wilson on duty.
Fri.,	May	1.—Dr. Graham and Mr. Girling Ball on duty.
Tues.,	,,	5.—Dr. Geoffrey Evans and Mr. Roberts on duty.
Fri.,	,,	8.—Prof. Witts and Prof. Paterson Ross on duty.
Sat.,	,,	9.—Hospital Sports.

EDITORIAL.

IT is with great regret that we announce Mr. Vick's resignation from his appointment as Warden of the College. When he was appointed in 1920 the Residential College was still in existence and, in fact, did not close until 1923. Since that time Mr. Vick has carried out the duties of the Warden in so far as the Medical College is concerned.

With his resignation one of the great traditional offices of the Hospital passes. Until 1923 the Residential College was an integral part of the Hospital and was under the control of the Treasurer and Almoners, to whom the Warden was responsible for the administration and discipline.

When the new Residential College opens—and it is an event we hope not far distant—the Warden will be entirely an officer of the Medical College and not of the Hospital. Mr. Vick, however, will remain as co-Treasurer of the Hospital.

During the sixteen years of his Wardenship Mr. Vick has been in touch with many successive generations of Bart.'s men, a great number of whom will remember him gratefully for his forbearance and personal interest, and deplore the fact that their successors will not have his help, as secretary of the Committee of Physicians and Surgeons, which nominates the Resident Staff. Another function of the Warden, which concerns us personally, is that of Censor of the JOURNAL. And it is a credit both to him and to us that, in the whole sixteen years, there has never been a serious difference of opinion nor protest about matter published in the JOURNAL. We hope in our next issue to publish an article by him on the history of the Office of Warden, and are sorry to lose his services.

He is to be succeeded by Dr. C. F. Harris, who will hold the appointment of Warden and Sub-Dean of the Medical College and will live in the new Medical College.

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We congratulate Sir George Newman, G.B.E., K.C.B., on the degree of Doctor of Laws, which was conferred on him on the occasion of the centenary celebrations of the University of London.

* * *

We also congratulate Dr. Mervyn Gordon, F.R.S., on the honour of the degree of LL.D., which has been offered to him by the senators of the University of Edinburgh.

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As we go to Press, we read with regret of the death of Sir Archibald Garrod. An obituary notice will appear in our next issue.

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The Eighth Annual Dinner of the 11th Decennial Club will be held at the Café Royal, Regent Street, on Friday, May 1st, at 7.15 for 7.30 p.m. Wilfrid F. Gaisford, M.D., M.R.C.P., will be in the Chair.

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The Annual Dinner of the Tenth Decennial Contemporary Club will be held at the Café Royal, Regent Street, W. 1, on Friday, May 8th, with P. Jenner Verrall, Esq., F.R.C.S., in the Chair. Cards will shortly be sent to members, and any member not receiving one should communicate with Mr. Arnold W. Stott, 58, Harley Street, W. 1.

OBITUARY.

DR. F. E. GIBBENS.

THE death of Dr. F. E. Gibbens at his residence at Barking, Essex, on March 1st, will be received by his many friends with deep regret.

Dr. Gibbens entered St. Bartholomew's Hospital with myself in October, 1883.

He had a great personality and was certainly the most popular student of his year with all. It mattered not to him in which section they moved. He was always jovial, amusing and extremely courteous. He was no ordinary student, as was marked by obtaining the Kirkes Scholarship and Gold Medal in Medicine so much coveted by all students. This distinction was a very popular one, even with those who had the advantage of an academic career.

It was in some respects peculiar how he was able to gain it. He was known to have been very interested in tabes dorsalis and had studied very closely every authority at home and abroad upon it, and had them all at his finger tips. As luck would have it one of the cases he was called upon to discuss was one of tabes. The examiners were, I believe, Dr. Andrew, Dr. Gee and Sir Dyce Duckworth, who were reported to have said Gibbens's report was a revelation to them. Dr. Gibbens practised in Barking ever since he qualified at the Conjoint Board in 1887, and by his personal charm, coupled with his skill, conducted an extensive practice.

In his early days he was Medical Officer of Health for Barking U.D.C., but preferred private practice to accepting the offer of a whole-time appointment. Dr. Gibbens was also a keen lecturer upon ambulance work for many years in the district.

He is survived by his widow and only son, who has nearly completed his course as a barrister. A. T. B.

GASTROSCOPY.

THE inspection of the gastric mucosa during life with the use of the gastroscope gives us a means of widening our knowledge of the pathological processes in the stomach, which has been very little used in this country. Much of the information we can get by gastroscopy cannot be obtained by any other method at our disposal.

By the direct inspection of the mucosa we can observe changes far more minute than by the best radiological methods, and differences in colour can be seen only by these means.

To the pathologist it is an even more exact examination than a post-mortem, for this is very severely handicapped by the changes which are produced in the colour and contour of the mucosa immediately before and after death.

Gastroscopy in the clinical investigation of the stomach occupies a place of rather less importance than cystoscopy in urology. This is because the radiological examination of the stomach is easier than the bladder, and can demonstrate with great accuracy ulcer and carcinoma, which are usually considered the only important diseases of the stomach. Gastroscopy is also a more troublesome procedure even to the male patient than cystoscopy, and although these two methods of investigation are of the same age, the gastroscope is still regarded as a curiosity.

In 1868 Kuszmaul persuaded a sword-swallower to allow him to introduce into his œsophagus a rigid metal tube 13 mm. in diameter. This tube had a gas-light attached to the proximal end but Kuszmaul saw nothing of the gastric mucosa, and it was not until 1879, when the use of electricity was better understood, that Nitze, the inventor of the cystoscope, constructed a gastroscope on the same principle and performed the first satisfactory gastroscopy. Mikulicz perfected the instrument, and after this there appear in the literature numerous names, of which perhaps the best known to us are Chevalier Jackson, Hill, Sussmann and Elsner.

At this time the gastroscope was the only reliable method of gastric diagnosis. With the development of the test-meal, interest in gastroscopy increased, but it was never widely used. The reason of course was that, at that time, it was an excessively dangerous procedure, anæsthesia was bad, and the instruments were crude.

At the beginning of this century, radiology, a new, easy and increasingly certain method of diagnosing the two most important gastric lesions, ulcer and carcinoma, displaced the unpleasant and dangerous method of gastroscopy. The diagnosis of chronic gastritis which has been so accurately and so frequently made with the gastroscope now became a refuge of ignorance. If a patient was found on X-ray examination to be suffering from neither carcinoma nor ulcer, he was probably labelled as gastroptosis, atonia, nervous dyspepsia or the like, but not as chronic gastritis, which was forgotten as a disease requiring treatment.

In Germany shortly after the war the interest in gastroscopy was revived by the work of Schindler, Elsner, Korbsch, Gutzeit and others, but owing to the fact that the instrument employed was rigid and that excessive skill and great care were necessary to avoid fatal accidents, its use still remained very limited.

In 1932 the instrument maker Georg Wolf of Berlin, by an ingenious arrangement of lenses, made a flexible gastroscope which gave a good and clear view (Fig. 1).

This gastroscope was tried out clinically, principally by Schindler of Munich, and also Norbert Henning of Leipzig. From this time the gastroscope has been used increasingly often in clinics on the Continent, and more recently in England.

I have used in my work here a flexible Wolf-Schindler gastroscope. This instrument is constructed on the principle of a cystoscope, but the distal 14 in. can be flexed through an angle of 45°, and the telescope is not removable. Illumination is provided by a strong 12-volt bulb, and the tip of the instrument has a buffer of sorbo rubber. The shaft carries an air canal which has a valve opening just proximal to the lens and air is pumped in with a hand bellows to distend the stomach. The field has an angle of 90°; the view obtained is like that of a cystoscope in perspective and clearness.

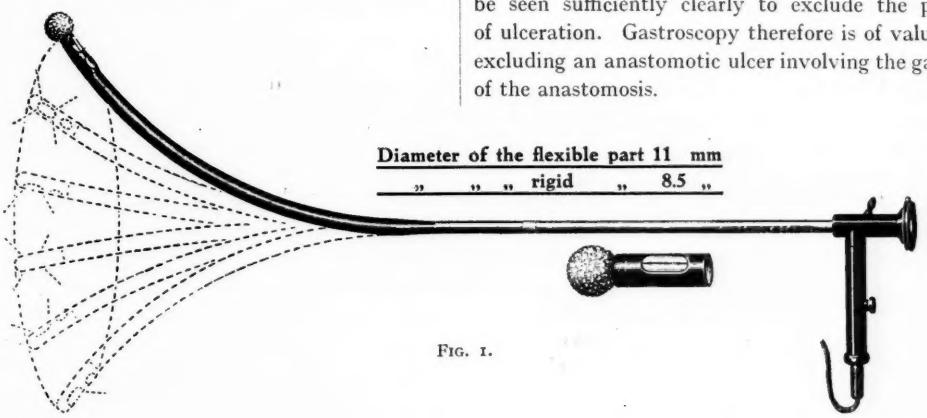

FIG. 1.

Owing to the large number of lenses through which the light has to pass the illumination is not brilliant enough for efficient photography. Photographs of the gastric mucosa can, however, be taken by two methods, the first with a camera which fits on to a rigid gastroscope which has fewer lenses and therefore a brighter light, secondly by the " blind " method, in which a small camera is lowered into the stomach at the tip of a stomach-tube. This camera has six minute lenses arranged round the circumference of the tube. The stomach is inflated with air, the camera is manipulated under the X-ray screen, a record of its position is made and the photographs are taken. This method is uncertain and of no practical value.

Gastroscopy is a very valuable supplement to the other methods of clinical diagnosis, and is indicated when the diagnosis is uncertain or incomplete. Gastritis cannot be diagnosed with certainty by any of the ordinary methods at our disposal, and it is therefore in the diagnosis of this condition and of its type and extent that gastroscopy is most useful. It is frequently found that a case of severe dyspepsia which has produced negative results by clinical, chemical and radiological examination will show on gastroscopy to have a severe gastritis which may yield to appropriate treatment.

The character of an ulcer may be left uncertain by the radiologist, and in a certain number of these cases it may be possible to decide by the use of the gastroscope whether the ulcer is malignant or not. It must, however, be realized that an early carcinomatous change in an ulcer can be diagnosed only on histological examination.

The diagnosis of gastro-jejunal ulcer is one of the most difficult problems that the radiologist has to solve, and it is similarly a difficult problem for the gastroscopist. In the majority of cases the stoma can be seen fairly well, but only rarely can the jejunal side of the stoma be seen sufficiently clearly to exclude the possibility of ulceration. Gastroscopy therefore is of value only in excluding an anastomotic ulcer involving the gastric side of the anastomosis.

In the anæmias X-rays give no reliable help in assessing the state of the gastric mucosa, but with the gastroscope the degree of atrophy of the mucosa can to some extent be estimated by its transparency, the character of the folds and their behaviour on inflation.

These, I think, are the main indications for gastroscopy in clinical practice. For research purposes, however, gastroscopy is an invaluable method of investigation.

Gastroscopy should be performed only after careful clinical examination and X-ray examination of the stomach. It is therefore supplementary to the usual methods of investigation.

The discomfort of gastroscopy under local anæsthesia varies, as does cystoscopy, with the type of patient. There is no doubt, however, that gastroscopy is a more unpleasant procedure, not because of the pain it causes, which is usually less than that of cystoscopy, but because of the nausea induced even with careful local anæsthesia. The only troublesome after-effect is sore throat, and this is not, as a rule, either severe or prolonged.

In Moutier's clinic in Paris the majority of his patients after being gastroscoped go straight home by "Metro", although Moutier himself says they sometimes feel "not so well".

There are certain obvious and rigid contra-indications to gastroscopy, such as œsophageal stenosis, aneurysm, intra-thoracic neoplasms and severe heart or lung disease. It should not be performed in cases of hæmatemesis, even when the patient is not seriously ill. The greatest risk of gastroscopy is perforation of the œsophagus, which has only been recorded at the lower end, where the œsophagus turns to the left as it passes towards the diaphragm. This accident has not occurred in the several thousand gastroscopies performed by Schindler, Henning and Moutier with the flexible gastroscope. It has occurred, however, with the use of the rigid gastroscope, and it was this accident which led to gastroscopy being given up in this country some few years ago. Perforation of the stomach even by the flexible gastroscope has occurred in cases of large friable carcinomata, but with reasonable care it should not occur even in this type of case.

Technique of gastroscopy.—The patient should be sent to the operating theatre in his ward clothes, just as if he were to have an X-ray examination. It is quite unnecessary for him to be prepared for a major operation, with his clothes back to front, hot-water bottles and near relations. It should be explained to him beforehand that he is going to have an investigation of his stomach which is rather like a stomach washout, but has to be done in the operating theatre because a special tilting table is necessary.

No food is allowed after the last meal the evening before, and therefore gastroscopy is best performed in the morning. The normal increase of blood-supply to the stomach which occurs during digestion may be mistaken for inflammatory hyperæmia if gastroscopy is not performed on a fasting stomach.

General or local anæsthesia may be used. While general anæsthesia has the advantage that the unpleasantness of the instrumentation is abolished, any anæsthetic which produces the relaxation required for gastroscopy is not in itself without risk. Also the œsophagus being relaxed, the air with which the stomach is inflated tends to regurgitate, so resulting in obstruction of the view by reason of the collapse of the stomach. Gas, ether and oxygen are unjustified unless the patient is having it for another operation, because of the post-anæsthetic vomiting and unpleasantness. Evipan has been used on a small series of cases and has been found satisfactory. It is given with the patient in the left lateral position ready for the intrument to be passed. The left arm is fixed to a plaster splint which is prepared beforehand, and the needle is kept in the vein throughout the entire examination, so that should it be necessary some more can be given. Mr. J. H. West, who has been kind enough to give the evipan for me, has found a dose of ·6 to ·9 grm. necessary.

Local anæsthesia has been used for the majority of my cases and with it some pre-medication is advisable. I have used a mixture of $\frac{1}{3}$ gr. omnopon, $\frac{1}{100}$ gr. hyoscine and $\frac{1}{100}$ gr. atropine, given $1\frac{1}{2}$ hours before gastroscopy. If an hour later the respirations are above 16 per minute a further $\frac{1}{3}$ gr. of omnopon is given. This usually produces a pleasant drowsiness and sometimes amnesia, while in only two cases out of 170 has the patient been unable to co-operate. Avertin and nembutal have been tried, but their effect is uncertain, and although the patient may not be able to co-operate, he may not be sufficiently deep to allow the gastroscopy to be performed.

To paint the pharynx, cocaine 10%, pantocain 2% (dessicaine), psicaine 2% and percain 2% have been used. There is not much to chose between them. Cocaine is more toxic than the others, pantocain is quicker in its action and percain rather more prolonged.

Using a 2 c.c. syringe with a long bent cannula the lips, gums, tongue, soft palate, fauces, posterior pharyngeal wall and hypopharynx are painted in that order. 2 c.c. of 2% pantocain is usually enough. The patient should be lying on his back. This position is preferred rather than the sitting position usually described, because the patient is more comfortable, and the anæsthetic introduced into the mouth runs back on to the posterior pharyngeal wall, where it is most needed.

After a few minutes' interval a stomach-tube is passed and the residual gastric juice aspirated. The patient is now placed in the left lateral position on the operating table, the hips and knees flexed, the back straight and resting against a firm support. The two anterior superior iliac spines are in a vertical line and also the shoulders. The neck is extended and the chin held forward. In this position the patient could see the under-surface of his chin in a mirror placed directly in front of him, and if this is explained to him the position is quickly arrived at. The head is held accurately in the midline by an assistant, who sits behind the patient. The gastroscopist sits facing the patient's head; two fingers of the left hand are passed into the mouth, the tongue depressed anteriorly and the gastroscope introduced with the right hand. A slight resistance is felt when the tip reaches the level of the cricopharyngeus. This is overcome by exerting gentle pressure and asking the patient to swallow. A little resistance may be met with at the diaphragm, which again should be overcome by gentle pressure and asking the patient to breathe deeply. At no time should

any force be used, and when the instrument is introduced it should be moved as little as possible upwards and downwards, and not at all from side to side, as these movements produce discomfort.

Special tables have been designed by Henning, Moutier and others. The only advantage which these tables have over the Bart.'s pattern operating table is that they have a special head-rest and can be rolled from side to side. As a skilled assistant is better than a mechanical head-rest, and the rolling can be as easily done by the gastroscopist himself moving the patient's right shoulder, I feel that these special tables are unnecessary.

After the gastroscope is introduced the flex and bellows are attached, and air is blown into the stomach until a view is obtained. It is important to have a

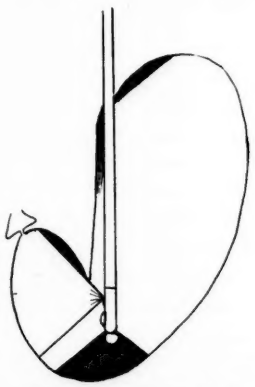

Fig. 2.—The Blind Areas of the Stomach of a "J"-Shaped Stomach.

good look round at this stage, as with greater inflation certain parts of the stomach may be so far displaced from the objective that the minute contour of the mucosa becomes indistinct. Inflation should stop if the patient complains of discomfort.

Orientation is one of the greatest difficulties of gastroscopy, and it is only by experience and bearing in mind a mental picture of the relation of the gastroscope to the stomach that this is made easier. This relation may be seen in an X-ray photograph. Certain landmarks are, however, easily recognizable. In the left lateral position the pylorus can be seen when the objective is pointing upwards at 12 o'clock, and the pool of mucus which collects in the most dependent part of the stomach at 6 o'clock. Towards 3 o'clock is the posterior wall and towards 9 o'clock the anterior wall. The mucosa of the anterior wall is usually less folded than the posterior in a normal stomach.

The area of stomach visible.—The area of the mucosa visible depends to a large extent upon the type of stomach, but with all types of stomach the highest part of the fundus, the region of the cardia, the upper part of the lesser curvature and the inferior pole of the stomach are always invisible (see Fig. 2). In the high cow-horn type of stomach the antrum is clearly seen, as Fig. 3 shows, but in a long low stomach whose antrum is bent sharply on the body, the lesser curvature beyond the angulus is invisible. It is obvious that included in these blind areas of the stomach there is a large part of the lesser curvature and sometimes the pylorus, and as

Fig. 3.—Showing the Pylorus and Pyloric Antrum.

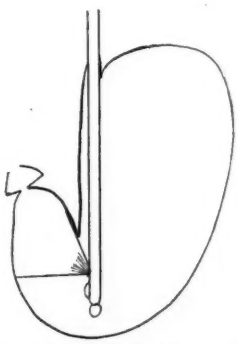

Fig. 4.—Retrograde Objective showing the Increased Visibility of the Pyloric Antrum.

it is here that so many important pathological lesions occur, this is a disadvantage of gastroscopy that must be overcome. There are many methods which we can use to bring these areas into view. On deep expiration the pylorus moves down relatively to the rest of the stomach and thus can be more easily seen. A retrograde objective will also allow a better view of the pyloric antrum (see Fig. 4). The lesser curvature immediately proximal to the angulus is always clearly visible, but in the upper part as the mucosa approaches the gastroscope the view becomes indistinct. To allow this upper part of the lesser curvature to be seen a small rubber balloon may be attached to the gastroscope immediately proximal to the objective

(Fig. 5). If this is inflated the lesser curvature is displaced to the right and is kept far enough away to be seen clearly. By using the balloon the entire lesser curvature above the angulus can be satisfactorily seen. By turning the instrument round, the balloon may be used to pull the cardiac end of the stomach a little upwards and increase the visibility of the fundus.

With the right-angle objective the inferior pole of the stomach is always invisible. As most gastro-enterostomy stomata lie somewhere near this spot they may be incompletely seen, and for this purpose a prograde or forward-looking objective is more useful (Fig. 6).

FIG. 5.—TO SHOW THE POSITION OF THE BALLOON WHICH WHEN INFLATED CAN DISPLACE THE LESSER CURVATURE.

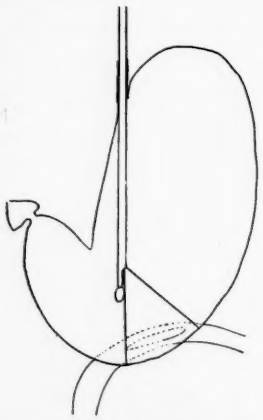

FIG. 6.—SHOWING THE USE OF A PROGRADE INSTRUMENT IN EXAMINING THE INFERIOR POLE OF THE STOMACH.

Colour of the mucosa.—The normal gastric mucosa is a deep orange-red colour. It is, however, difficult to decide in any particular case whether the mucosa is paler or darker than usual. A duodenal tube on which three bands of colour have been painted can be used as a standard against which to compare the colour of the mucosa. The tube is introduced before the gastroscope instead of the larger stomach-tube. Through it the fasting juice is aspirated and it is kept in position. This adds little if anything to the difficulty in passing the instrument or to the patient's discomfort.

Sore throat is the only important complication after gastroscopy, but it unfortunately occurs fairly frequently. Its causes are trauma, which may be produced either by the struggling or rigidity of the patient, roughness on the part of the surgeon, or roughness of the gastroscope, and since I have waxed the rough areas of the gastroscope as was suggested to me by Prof. Witts, I have found that the incidence of sore throat has been reduced. Other causes are the prolonged dryness of the mouth and use of too much anæsthetic. 2 c.c. of pantocain are usually enough. This will give anæsthesia lasting about one hour, after which the patient is given a mouth-wash and something to eat and drink.

MEMORIES OF MACKENZIE'S.

HOW quickly the past disappears! Even the bricks of what was once Mackenzie's, the old house in which midwifery clerks of the early days of the twentieth century lived, have long ago crumbled into dust.

It was with some such thoughts as these that last week I passed the site of the old house in Cloth Fair where I had once learned the practice of midwifery. Scenes that I thought had been long forgotten flickered through my mind. Again I heard the clanging of that bell that waked the clerk on duty from his slumbers in the early hours of the morning. Poking my head out of the window I again saw the frenzied husband battering at the door.

"Better come quickly," he would shout, "the pains are getting something chronic". Then bundling into clothes and seizing our little black bags, I and my companion would hurry down to the door to be conducted by devious by-ways into some tenement house at the back of Goswell Road. Up the stairs, falling over a pail in the dark passage, we would reach a lighted room in which lay a woman groaning and clutching at the bedclothes. Everything was all right now; the processes of Nature could proceed. Two gentlemen from St. Bartholomew's were in attendance.

Frankly I disliked the whole business, and wished that Nature had devized some other method of bringing new creatures into the world. With hands laid upon the abdomen we were expected to feel the position of the child, how it was faring, and whether its arrival into the world was proceeding according to the rules of the text-books. Actually I felt nothing except a very stout woman and some knobs like plums in a vast suet pudding. The whole thing was preposterous, and I should never have been asked to do it.

Nevertheless I could not help liking Mrs. Honeybun. She had acquired this name in Dorset, where Honeybuns are by no means unknown, but her husband, a tram

conductor, was now residing in London. Podge Oulton and I had been summoned to her couch at 3 o'clock in the morning. It looked like a simple case, for Mrs. Honeybun had already a family of three, and knew how to pull on the towel tied to the foot of the bed. I had made a preliminary examination, discovering even less than usual except that the lady was unusually big. Now I was listening through my stethoscope to a strange noise like a kettle boiling in the patient's interior.

Mrs. Honeybun was impressed. "What is it, doctor? Is it a boy?"

"A fine boy, Mrs. Honeybun. I congratulate you."

"Oh, I'm so glad! You see, doctor, I've got three girls and my husband wants a boy."

The conversation was interrupted—things were evidently coming to a head. "Pull, Mrs. Honeybun. That's right. Put your feet against the bed. Now another."

It was over surprisingly quickly, and Mrs. Honeybun was soon lying comfortably in her bed, tired but satisfied that she had done her bit. A rather undersized daughter wrapped in a towel lay beside her. The placenta had come away nicely, and the uterus, though still rather large, was not bleeding more than seemed reasonable. The two doctors, having achieved this miracle, could now retire to the street for a cigarette whilst the friend who was acting as nurse washed their mackintoshes.

"Well, that's that," said Podge, "and a good job too."

"Nice woman, the Honeybun," I answered. "I'm glad she did all right, though I'm sorry it wasn't a boy."

Suddenly a window opened above us and the nurse screamed, "Come quick."

"What's the matter?" I shouted, "Too much blood coming?"

"No, a baby."

The face disappeared, so it was no good asking for more information. "Post-partum hæmorrhage" I gasped, and made for the door. It was my case, but Podge was before me. Up the stairs he went with the speed that had earned him his blue. He beat me by at least two flights, and by the time I had reached the room it was all over. In his hands was a screaming boy. He turned to me.

"Just caught it before it bounced on the floor."

Mrs. Honeybun was one big smile.

"There, I knew you wouldn't deceive me, doctor. I just felt I could leave everything in your hands. But why didn't you tell me about the girl?"

"A little surprise" I answered truthfully. "That's all, a little surprise."

"Lord," said Mrs. Honeybun, "I hope there aren't no more!"

"No more, Mrs. Honeybun. I promise you that. What will you call him?"

Mrs. Honeybun thought deeply for a moment, than looked slightly embarrassed. At last she spoke.

"Do you mind telling me your name?"

"Kenneth," I answered.

"What a lovely name! He shall be Kenneth, and I hope he will grow up half as clever as you."

We parted the warmest of friends. I never saw her or my namesake again, but if by any chance a Kenneth Honeybun should read these pages, and should feel that during his entry into the world he did not receive the medical attention to which he was entitled, will he please recall that his mother was very fat!

IN PRAISE OF SLEEP.

MR. HAROLD NICOLSON has told how he, the youngest member of the Foreign Office staff, was sent urgently to the German Embassy on the night of August 4th, 1914, to recover a document which stated, in effect, that England and Germany were at war and which had been sent, by mistake, some hours before that statement became true. In a state of considerable mental agitation, for the situation was a delicate one, he was shown into the Ambassador's bedroom. Prince Lichnowsky lay in bed; on a table beside him lay the premature document, unopened.

Now that time has mellowed the unfriendly tones of the contemporary picture, how deeply can we appreciate the Prince's calm philosophy, his balance of mind in that unhappy moment. A lesser man would have seized the dispatch, read its contents, summoned his secretaries, marshalled his attachés and settled down to a hard night's work, writing reports, collecting papers, making arrangements for his departure. But Prince Lichnowsky had a fuller realization of the implications of the position. He knew only too well what that letter must contain—he knew that now his work in London was ended. And meanwhile, it was bedtime. Why spend the precious hours in futile activity when he might with a clear conscience spend them on his brass bedstead deep in the enjoyment of sleep? Why, indeed? For of all the pleasures which the world can offer, few can be accounted more precious than sleep. Poets have sung its praises, Shakespeare has said something about it somewhere, thousands will testify every day to its virtues; yet, save by those who are unable to get it, sleep is still denied its proper value among the blessings of this life.

"The utmost that can be said," wrote Samuel Butler, "is that we are fairly happy so long as we are not distinctly aware of being miserable". One is driven to the conclusion that Butler must have been a very poor sleeper. For no true narcophile could deny the positive happiness imparted by the process of going to sleep—by lying in bed, exquisitely tired, pulling the bedclothes closer and, with a sigh, abandoning oneself to the worship of Morpheus.

I have often wondered whether it would be possible to devise some means of keeping sufficient of one's mind awake to enjoy the long hours of complete unconsciousness which, because of that unconsciousness, go entirely to waste. Even dreams, which are by no means always enjoyable, are said to occupy only a moment of time before we awake. Our enjoyment of sleep lies, not in the sleeping, but in the seeking of sleep and in the wakening. Its highest peak, perhaps, comes when one wakes to realize that there is still an hour or more for sleep. There are some people, I am told, who, once awake, cannot sleep again but must perforce get up. How I pity them! They can never know the delight of turning over on to the other side, where one achieves a state of comfort quite sublime, and sinking back once more into unconsciousness. But one has only to contemplate a sleeping creature to believe that there is some happiness to be had even in the unconscious state. The Chesapeake and Ohio Line advertises the comforts of its sleeping-cars to the public of the United States with the slogan, "Sleep Like a Kitten". And to ram the lesson home, they accompany it with a picture of that kitten tucked between the Chesapeake and Ohio Line's sheets, so obviously enjoying its sleep that one feels an impulse to sail at once for New York for the single purpose of travelling to St. Louis in a state of similar bliss.

Like a kitten—what genius lies behind the choice of that phrase! For the kitten, and indeed the adult cat, is perhaps the most accomplished sleeper of the animal world. One feels that it contrives to wring the last drop of enjoyment out of its slumber. The dog, too, sleeps well, but with a savage abandon and with none of that appearance of gifted artistry which belongs to the cat. There are, of course, among animals some wretchedly bad sleepers. I cannot, for instance, recollect ever to have seen a cow asleep. But then, I never had a very high opinion of the intelligence of the cow.

Every silver lining (the phrase is not mine) has its cloud. And every sleep must come at last to the moment of getting up. The agony of that moment is almost too great a price to pay. I have tried putting the alarm clock at the other end of the room, I have tried drinking tea, I have even followed Dr. Strabismus (whom God preserve) of Utrecht and tried tying two pieces of string together: these things may quicken the process, but they cannot lessen the pain. Almost as bitter is the pain of being compelled to stay awake when sleep calls with all its might, bids with all its persuasion for possession of one's soul. May I be preserved from the risk of being frozen to death when, one is told, to yield to the almost overwhelming drowsiness is fatal. In such a circumstance I must surely perish. Φ

MR. PICKWICK'S BIRTHDAY.

(A lecture delivered to the Abernethian Society on March 5th, 1936.)

By Mr. BERNARD DARWIN.

THE hundredth anniversary of Mr. Pickwick's first appearance falls on March 31st this year. Some people, of course, know him very well; but there are others, in the words of Sergeant Buzfuz, "beings erect upon two legs and having all the outward semblance of men and not of monsters", who know him very little. I must apologise, then, to the learned, if I am too elementary, and to the unlearned, if I am too subtle.

A great many people here know all about the origin of Pickwick, and I shall not go into it at length; but at the risk of going over old ground it is perhaps just worth while pointing out this. Here is one of the indubitably great books of the world, and it came into being almost by a fluke. There was a popular artist called Robert Seymour, who drew pictures of sporting cockneys. They were successful, and he told Chapman and Hall that he would like to do some more. They had then to look about for somebody, who would in effect write some matter to accompany the pictures. They thought of several people—they even wrote to one, and very fortunately he did not answer the letter. Then they remembered there was a handy young man called Dickens, who had written some good little sketches and they would be able to get him cheap. Mr. Hall went to see him and suggested a Nimrod Club, but the handy young man was not perhaps quite as overwhelmed and compliant as they expected. He said the club was an old idea, that he was not much of a sportsman and that he would probably take his own way in the end. However, he adopted the Club to please the publishers and put in Mr. Winkle to please Seymour. The story appeared in monthly instalments, and before the second number came out, Mr. Seymour, for no particular reason, shot himself. There was a rush to find another illustrator, and they found a gentleman called Buss, who painted facetious Academy

pictures of Sir Walter Raleigh and his pipe—he has had many counterparts since; the result was hopeless, and he had to be sacked. They had incidentally rejected John Leech and Thackeray in the search. They then got Hablot K. Browne, who suited very well. Dickens was, of course, under no sort of obligation to fit himself to his new illustrator as he had to Seymour, and incidentally the original cover of Pickwick shows a stout gentleman fishing from a punt. If Seymour had continued, either Mr. Pickwick or Mr. Winkle or both would have had to fish. As it was Dickens now took the bit between his teeth and did what he pleased. With the fifth number came Sam Weller, and what had been a moderate success became a craze. One of the most pleasant pieces of evidence of this surge of popularity came, incidentally, from Carlyle. "An Archdeacon," he wrote, "with his own venerable lips repeated a strange profane story of a solemn clergyman, who had been a ghostly consolation to a sick person. Having finished satisfactorily, as he thought and left the room, he heard the sick man ejaculate, 'Well, thank God, Pickwick will be out in ten days anyway'".

Dickens was now a made man over and over again, but the fact remains that only a little while before he had been a backwriter, who would have to write round Seymour's pictures. So much for the beginnings, and now I propose to touch on a more topical aspect of the subject, suggested by the audience.

If Mr. Bob Sawyer and Mr. Ben Allen had been at Bart.'s they would doubtless have been shining lights of the Abernethian Society. But they were not at Bart.'s, for Dickens better understood their spiritual home and sent them to Guy's. Mr. Sawyer, you will remember, "had about him that slovenly smartness and swaggering gait, which is peculiar to young gentlemen who smoke in the streets by day, shout and scream in the same by night, call waiters by their Christian names and do various other acts and deeds of an equally facetious description". Dickens was no doubt right in sending them to Guy's.

An illustrious profession has rather suffered from Mr. Sawyer and Mr. Allen—though not as much as the ladies have suffered from Mrs. Gamp. Yet I hope I can show you that Mr. Sawyer and Mr. Allen were, in many ways, much maligned people, and had many qualities wholly desirable in their profession. First of all they were extremely enthusiastic about their work:

"Nothing like dissecting, to give one an appetite," said Mr. Bob Sawyer, looking round the table.

Mr. Pickwick slightly shuddered.

"By the bye, Bob," said Mr. Allen, "have you finished that leg yet?"

"Nearly," replied Sawyer, helping himself to half a fowl as he spoke. "It's a very muscular one for a child's."

"Is it?" inquired Mr. Allen, carelessly.

"Very," said Bob Sawyer, with his mouth full.

"I've put my name down for an arm at our place," said Mr. Allen. "We're clubbing for a subject, and the list is nearly full, only we can't get hold of any fellow that wants a head. I wish you'd take it."

"No," replied Bob Sawyer, "can't afford expensive luxuries".

"Nonsense!" said Allen.

"Can't indeed," rejoined Bob Sawyer, "I wouldn't mind a brain but I couldn't stand a whole head".

At this point they were hushed by Mr. Pickwick owing to the ladies' arrival, but later Mr. Sawyer, under the influence of brandy and breakfast, "ripened into a state of extreme facetiousness, and related with much glee an agreeable anecdote about the removal of a tumour on some gentleman's head, which he illustrated by means of an oyster knife and a half quartern loaf".

The same professional keenness was noticeable when the Pickwickians went to supper with Mr. Sawyer at Lant Street, and here we come to an ornament of this Hospital, and a very great ornament too—Mr. Jack Hopkins. The conversation turned on the surgical skill of Mr. Slasher:

"You consider Mr. Slasher a good operator?" said Mr. Pickwick.

"Best alive," replied Hopkins. "Took a boy's leg out of the socket last week—boy ate five apples and a ginger-bread cake—exactly two minutes after it was all over, boy said he wouldn't lie there to be made game of and he'd tell his mother if they didn't begin."

"Dear me!" said Mr. Pickwick astonished.

"Pooh! that's nothing, that ain't," said Jack Hopkins, "is it Bob?"

"Nothing at all," replied Mr. Bob Sawyer.

"By the bye, Bob," said Hopkins, with a scarcely perceptible glance at Mr. Pickwick's attentive face, "we had a curious accident last night. A child was brought in, who had swallowed a necklace".

"Swallowed what, sir?" interrupted Mr. Pickwick.

"A necklace," replied Jack Hopkins. "Not all at once, you know, that would be too much—you couldn't swallow that, if the child did—eh, Mr. Pickwick, ha! ha!" Mr. Hopkins appeared highly gratified with his own pleasantry, and continued, "No, the way was this child's parents were poor people who lived in a court. Child's eldest sister bought a necklace; common necklace, made of large black wooden beads. Child, being fond of toys, cribbed the necklace, hid it, played with it, cut the string, and swallowed a bead. Child thought it capital fun, went back next day and swallowed another bead".

"Bless my heart," said Mr. Pickwick, "what a dreadful thing. I beg your pardon, sir. Go on".

"Next day, child swallowed five beads: the day after that, he treated himself to three, and so on, till in a week's time he had got through the necklace—five-and-twenty beads in all. The sister, who was an industrious girl, and seldom treated herself to a bit of finery, cried her eyes out, at the loss of the necklace; looked high and low for it; but, I needn't say, didn't find it. A few days afterwards, the family were at dinner—baked shoulder of mutton, and potatoes under it—the child, who wasn't hungry, was playing about the room, when suddenly there was heard a devil of a noise, like a small hailstorm. 'Don't do that, my boy,' said the father. 'I ain't a doin' nothing,' said the child. 'Well don't do it again,' said the father. There was a short silence, and then the noise began again, worse than ever. 'If you don't mind what I say, my boy" said the father, 'you'll find yourself in bed, in something less than a pig's whisper'. He gave the child a shake to make him obedient, and such a rattling ensued as nobody ever heard before. 'Why, dam'me, it's *in* the child!' said the father, 'he's got the croup in the wrong place!' 'No I haven't father,' said the child, beginning to cry, 'it's the necklace; I swallowed it, father'.—The father caught the child up, and ran with him to the hospital: the beads in the boy's stomach rattling all the way with the jolting; and the people looking up in the air, and down in the cellars, to see where

the unusual sound came from. He's in the hospital now," said Jack Hopkins, "and he makes such a devil of a noise when he walks about, that they're obliged to muffle him in a watchman's coat, for fear he should wake the patients!"

"That's the most extraordinary case I ever heard of," said Mr. Pickwick, with an emphatic blow on the table.

"Oh, that's nothing," said Jack Hopkins; "is it, Bob?"

"Certainly not," replied Mr. Bob Sawyer.

"Very singular things occur in our profession, I can assure you, sir," said Hopkins.

"So I should be disposed to imagine," replied Mr. Pickwick.

I am disposed to imagine that this was one of the few occasions when Mr. Pickwick was in his innocence inclined to doubt whether he was being told the exact truth.

Again Mr. Sawyer was a man of strong and independent views and not afraid of airing them. Mr. Pickwick you know fell through the ice into the pond at Dingley Dell. Mr. Ben Allen thought it would be a good thing to bleed the company generally, but Mr. Sawyer, we are inclined to think, did not approve. Mr. Pickwick was wrapped up in shawls and taken home to bed, and the whole company assembled in his room to drink hot punch.

Next day there was not a trace of rheumatism about him, which proves, as Mr. Bob Sawyer very aptly observed, that there is nothing like hot punch in such cases, and that, if ever hot punch did fail to act as a preventive, it was merely because the patient fell into the vulgar error of not taking enough. That was an error at any rate into which Mr. Sawyer never fell himself; on another occasion he made rum punch in a mortar and stirred it with a pestle in a highly creditable and apothecary-like manner. He was in fact a physician, who practised what he preached.

When Mr. Sawyer went into practice at Bristol I am not sure that his conduct was quite worthy of his career at his hospital. You know more about this sort of thing than I do, and I do not think that the General Medical Council would have wholly approved of him. He came terribly near the infinite crime of advertising, and what is more, he followed an irregular practice;

"Did you leave all the medicine?"

"Yes, Sir."

"The powders for the child at the large house with the new family. And the pills to be taken four times a day at the old gentleman's with the gouty leg?"

"Yes, Sir."

"Then shut the door and mind the shop."

"Come," said Mr. Winkle as the boy retired, "you are not quite so bad as you would have me believe either. There is some medicine to be sent out".

Mr. Bob Sawyer peeped into the shop to see that no stranger was within hearing, and leaned forward to Mr. Winkle said in a low tone, "He leaves it all at the wrong houses".

Mr. Winkle looked perplexed and Bob Sawyer and his friend laughed.

"Don't you see," said Bob, "he goes up to a house, rings the area bell, pokes a packet of medicine without a direction into the servant's hand and walks off. Servant takes it into the dining parlour; master opens it and reads the label; Draught to be taken at bed time—pills as before—lotion as usual—the powder. From Sawyer's late Nockemorf's. Physician's prescriptions carefully prepared and all the rest of it. Shows it to his wife—she reads the label; it goes down to the servants—they read the label. Next day, boy calls; very sorry—his mistake—immense business—great many parcels to deliver—Mr. Sawyer's compliments—late Nockemorf. The name gets known, and that's the thing, my boy in the medical way, bless your heart, old fellow it's better than all the advertising in the world. We have got one four ounce bottle that's been to half the houses in Bristol and hasn't done yet".

"Dear me, I see," observed Mr. Winkle, "what an excellent plan".

"Oh, Ben and I have hit upon a dozen such," replied Bob Sawyer with great glee. "The lamplighter has eighteen pence a week to pull the night bell for ten minutes every time he comes round; and my boy always rushes into Church, just before the psalms when the people have got nothing to do but look about them, and calls me out, with horror and dismay depicted on his countenance. Bless my soul, everybody says, somebody taken suddenly ill! Sawyer, late Nockemorf, sent for; what a business that young man has."

I ought to add finally that both Mr. Sawyer and Mr. Allen were persons of elastic mind not incapable of admitting they were wrong—no doubt a frequent occurrence. When they were in India they each had yellow fever fourteen times, and decided to try a little abstinence. The last we hear of them is they were doing well.

There are other members of the profession in Pickwick, though less famous. There was, for instance, Dr. Slammer of the 97th Regiment and Dr. Payne of the 43rd at Rochester, but they were more concerned with duelling than doctoring. There is another, however, to whom I must draw your attention because he had what I venture to imagine must be a valuable gift in difficult cases when, if this ever arises, you don't know what's the matter. It consists of adapting the diagnosis to the statements of the patient. He comes into the story that Sam Weller told his master about the little man who ate crumpets:

"One night he wos took very ill; sends for the doctor; doctor comes in a green fly, with a kind o' Robinson Crusoe set o' steps, as he could let down wen he got out, and pull up arter him wen he got in, to perwent the necessity o' the coachman's gettin' down, and thereby undeceivin' the public by lettin' 'em see that it wos only a livery coat as he'd got on, and not the trousers to match. 'Wot's the matter?' says the doctor. 'Wery ill,' says the patient. 'Wot have you been a eatin' on?' says the doctor. 'Roast weal,' says the patient. 'Wot's the last thing you dewoured?' says the doctor. 'Crumpets,' says the patient. 'That's it!' says the doctor. 'I'll send you a box of pills directly, and don't you never take no more of 'em,' he says. 'No more o' wot?' says the patient —'Pills?' 'No; crumpets,' says the doctor. 'Wy?' says the patient, starting up in bed; 'I've eat four crumpets, ev'ry night for fifteen year, on principle'. 'Well, then, you'd better leave 'em off, on principle,' says the doctor. 'Crumpets is wholesome, sir,' says the patient. 'Crumpets is not wholesome, sir,' says the doctor, wery fierce. 'But they're so cheap,' says the patient, comin' down a little, 'and so wery fillin' at the price.' 'They'd be dear to you, at any price; dear if you wos paid to eat 'em,' says the doctor. 'Four crumpets a night,' he says, 'vill do your business in six months!' The patient looks him full in the face, and turns it over in his mind for a long time, and at last he says, 'Are you sure o' that 'ere, sir?' 'I'll stake my professional reputation on it,' says the doctor. 'How many crumpets, at a sittin', do you think 'ud kill me off at once?' says the patient. 'I don't know,' says the doctor. 'Do you think half a crown's wurth 'ud do it?' says the patient. 'I think it might,' says the

doctor. 'Three shillins' wurth 'ud be sure to do it, I s'pose?' says the patient. 'Certainly,' says the doctor. 'Wery good,' says the patient; 'good night.' Next mornin' he gets up, has a fire lit, orders in three shillins' worth o' crumpets, toasts 'em all, eats 'em all, and blows his brains out."

"What did he do that for?" inquired Mr. Pickwick abruptly; for he was considerably startled by this tragical termination of the narrative.

"Wot did he do it for, sir?" reiterated Sam. "Wy in support of his great principle that crumpets wos wholesome, and to show that he wouldn't be put out of his way for nobody!"

So much for the doctors, and now we come back to Mr. Pickwick's Birthday. There is, as far as I know, only one piece of evidence in the book that is more or less conclusive. He was called "Dear old thing" by Miss Arabella Allen, with the fur round her boots, and "Jolly old gentleman" by Mr. Jingle. Well, Mr. Pickwick was at the most, I should say, 44.

When Mr. Pickwick was asked to slide he said, "I used to do so in the gutters when I was a boy". On being further pressed he added, "I should be very happy to afford you any amusement as I haven't done such these 30 years".

I think that 15 is as old as we can reasonably put the age of a boy. Mr. Pickwick would have gone into business at 16, and 15 and 30 make 45.

Many of our notions of the ages of people in Pickwick have to be reconsidered in the light of uncompromising fact. Mrs. Wardle is called a very old lady. She was very deaf; she never went out. But we have it on the unimpeachable authority of Mr. Perker, the family solicitor, that she was not yet 73. To-day she would be a giddy young thing going to cocktail parties. Her son is constantly alluded to as "The jolly old gentleman". Well, he said rather unchivalrously to his sister, "you're fifty if you are an hour". So perhaps he was about 52. I suppose the explanation is partly that people a hundred years ago almost deliberately got old earlier and would have nothing to do with times changing. The other reason no doubt is as old as the human race, namely, the tendency of young gentlemen to deem rather older ones senile.

Dickens was, as I say, a very young man. He was 23, and one of the astonishing things about Pickwick is the way in which at 23 he leaped in one single prodigious bound to the very top of the tree. I think he climbed to a greater height than he ever reached again. He had not been an infant phenomenon. As you may know, he had been writing verses in the album of Miss Maria Bladnell, who was long afterwards to be Dora in *David Copperfield*. They were not merely youthfully crude and turgid, but excruciatingly bad. Anybody who had read them would have told him that whatever else he did he must never think of writing. Then came his first story, *Mr. Minns and his cousin*—a very mild little story; and then there were *Sketches by Boz*. Well, eminent people now apply all sorts of epithets to *Sketches by Boz*. Somebody was doing it in the *Times* the other day, and all I can say is that I can't agree, and that the eminent persons are only being wise after the event. I think if any astute editor had read them he would have said that the writer had remarkable powers of observation, that he would write a very good account of a fire or an inquest, that he was just the man to get on his paper as a descriptive reporter; but I very much doubt whether anybody would have seen that this was going to be one of the greatest figures of English literature. Then came this one chance, though it did not look much of a chance, and see what he made of it. Because it was his first chance, Dickens poured into his book everything that was seething and bubbling in his head. Ordinary people who write for a living make their ideas, such as they are, go as far as possible. The poor journalist says, "This joke will do for Saturday's article; I'll keep the other for Saturday week". Even highly respectable novelists spread the jam of their ideas as thin as they can and keep some up their sleeve. Great men do not do that, and I may give as an instance a great modern humourist, Mr. P. G. Wodehouse. One of his stories is a glorious and generous hotchpot of notions, each of which would have made half a dozen stories for a lesser master. So it was with Dickens, and as a result the book was, as Mr. Chesterton calls it, "a kind of wild promise, a pre-natal vision of all the children of Dickens". And I will dare to say this—that with perhaps one exception, Dickens showed in Pickwick that he could do every kind of thing as well as ever he did it afterwards.

Dickens's supreme achievement is the creation of great comic characters. Yet you may pick a team from all the other books put together—Mr. Micawber, Dick Swiveller, Mr. Toots, Mr. Guppy and Mrs. Gamp—and find another team out of Pickwick to make a match of it. Let us say Mr. Pickwick, the two Wellers, Bob Sawyer and Solomon Pell. In sheer power of description he never afterwards excelled the scenes in the Fleet Prison, not even in the Marshalsea in *Little Dorrit* or in Newgate in *Great Expectations*. It is, however, his power to portray pathos on which I would lay emphasis for a moment, for Dickens became rather a professional describer of death-beds, and his contemporaries wept buckets over them, Little Nell, Little Paul, Little Johnny—all children. We do not nowadays think them very good because Dickens seems to stop, take his coat off, roll up his sleeves and say, "I am going to be pathetic". The death-bed of Mrs. Weller, on the other hand, when he keeps himself under restraint, is really magnificent, and I would read it to you if I were not

afraid of being, like Mr. Job Trotter, a portable steam engine over it. One thing Dickens learnt afterwards—the wonderful power of atmosphere by which he warned us of terrific things to come, but he never did that in Pickwick, because he did not need it.

I suppose that of all the great characters in the book everyone would agree there is one outstanding and mighty triumvirate—Mr. Pickwick, Sam Weller and Tony Weller. Sam made the book to begin with; his father, when he arrived later, used to play him off the stage and is, perhaps, the most towering creation of all, but there can't be any doubt as to which is the most lovable. That was Mr. Pickwick himself; as Sam remarked, "He was a reg'lar thoroughbred angel". There is an endless and rather futile argument as to whether Dickens could or could not draw a gentleman. He certainly made some very bad shots at it when young, with some of his villainous aristocrats, who stepped straight from what would have later been called Adelphi melodrama. He did it much better later with his cousin Feenix and Sir Leicester Dedlove. But what is the use of talking when at the very outset he created Mr. Pickwick? If Mr. Pickwick is not a gentleman, then a gentleman is what Mr. Tony Weller calls "A fabulous animal like a griffin or a unicorn on a King's Arms". He was as honourable, as upright, as sensitive, as considerate for other people's feelings as any man that ever lived, and as for mere politeness, just think of him when he got into the lady's bedroom by mistake at Ipswich: "I am almost ready to sink, Mam, beneath the confusion of addressing a lady in my night cap, but I can't get it off Mam."

It may be said against Mr. Pickwick that he sometimes took too much cold punch. Well, so he did; but it was an amiable weakness, and so did many a fine gentleman of his time. Remember also that he gave it up, and after he had been wheeled to the pound he was never drunk again. The worst that ever happened to him was when he went to sleep.

Finally there is one to me most lovable quality in him—that he was the eternally romantic child. He had all the power we had as children of finding romance in ordinary workaday things. What else was it made him so excited over the journey to Dingley Dell, when he watched the packing of the oysters and the codfish? We used to be like that when we started with a bucket and spade. What but romance made him rejoice in his speckled silk stockings at the ball, or what else made him think he had made a great discovery when he dug up the old stone in Cobham? And lastly, think of him when he insisted, quite superfluously, on taking a dark lantern when he went to be a chaperon to Mr. Winkle when he proposed to Miss Arabella Allen. It is then that Sam Weller showed how truly he understood his master:

> "Where is he?" asked Mr. Winkle.
> "Bless his old gaiters," rejoined Sam, "He's akeepin' guard in the lane with that 'ere dark lantern like a Amiable Guy Fawkes! I never see such a fine creetur in my days. Blessed if I don't think his heart must have been born five and twenty years arter his body at least."

In that sentence is summed up the supremely lovable quality of the most lovable of men. That is the reason why we can laugh at him so tenderly. Sam's is the perfectly worded benediction, "Bless his old gaiters".

NOTES ON BLOOD TRANSFUSION.

TAKING BLOOD.

BEFORE attempting to do this, always put a sphygmomanometer on the arm and raise the pressure to about 100 mm. of mercury.

Beware of mobile superficial veins even if they are temptingly large; deeper and more fixed veins are much easier to enter.

The type of needle used is a matter of taste, but if a negative pressure system is employed, a rapid flow may be maintained with a relatively small-bore needle; if no such system is available a sharp French's needle can be used without undue injury to skin or vein, provided that the former is infiltrated with novocain, and a minute longitudinal incision is made over the vein.

Remember that blood will flow readily if the needle is in the lumen of the vein, and so-called venospasm is so rare that it is wise always to attribute failure to obtain blood to faulty technique.

When blood is taken for continuous drip transfusion at least two and, if possible, three donors should be venesected at a time to prevent the supply of blood becoming exhausted during the night, when it may be difficult to obtain.

GIVING BLOOD.

As in the taking of blood, it is advisable to apply a sphygmomanometer, but care must be taken to release the pressure before attempting to introduce the blood.

It is not usually necessary to cut down on the recipient's vein except in small children and sometimes in obese women. If a trocar and cannula type of needle is used, its introduction into the vein can be facilitated by first incising the skin in a manner similar to that described under the heading "Taking Blood".

Whatever apparatus is used care must be taken to

exclude all air by running normal saline through it. In continuous drip transfusion this is particularly important, as the long length of pressure tubing used makes the complete removal of air more difficult. The container or flask should therefore be filled about half full of saline, which should be allowed to run out until the level is below the filter; if this is not done, when the blood is introduced a deposit is formed on the filter which is apt to impede the flow of blood.

If the blood ceases to flow or the rate of flow gradually diminishes the flask should be gently shaken and the regulating clip unscrewed for a few seconds, after which it can be readjusted to its original position.

In continuous drip transfusion it is usually advisable to cut down on a vein situated low down on the dorsal aspect of the forearm, and to introduce as large a cannula as possible. Small cannulæ are often unsatisfactory, as the blood tends to clot in them more readily, particularly if it is being given very slowly.

Cotton-wool should be applied over the whole forearm and held in position with a bandage in order that the blood passing down the tube may be kept as warm as possible.

In all types of blood transfusion manipulation of the blood should be reduced to a minimum, and the blood should be kept as nearly as possible at body temperature.

If the first attempt either to take or to give blood proves unsuccessful owing to failure to introduce the needle into the vein, it is better to make the second attempt on the same arm, provided there is another vein, rather than on the other arm, for by so doing the inconvenience and disability of two sore arms may be avoided.

STUDENTS' UNION.

At the Annual General Meeting of the Students' Union, Mr. Mundy, presenting the Secretaries' Annual Report, said: "GENTLEMEN,—We have pleasure in presenting to you the thirty-second annual general report of the Students' Union.

"The past year has been eventful in that last October the buildings at Charterhouse Square were opened for the use of all pre-clinical departments except Anatomy and Biology. These two departments, however, will be moving shortly as their buildings are almost completed. The Ground and Gymnasium are still invaluable for training purposes. It is hoped also that in the near future two standard squash rackets courts will be built.

"During the year the Abernethian and Writing Rooms have been completely refurnished. This has improved considerably the appearance and comfort of the rooms, and it is earnestly hoped that students will continue to look after them.

"The Annual Dance was held at Grosvenor House last November. There was a record attendance of over 500 people. The receipts show a profit of £45 10s. 8d. The students' contribution to the College appeal fund is now over £1000; nevertheless, with the present number of students it should be higher. As usual, considerable success has attended the activities of the clubs of the Union."

Mr. Mundy then briefly reviewed the past year and the accomplishments of the various clubs. The Rugby Football Club had had a disappointing season so far as the 1st XV was concerned, though the "A" and "B" XV's had been more successful. In the Hospitals Cup we were defeated in the semi-final by St. Thomas's. The Cricket Club, too, could hardly boast of its achievements. This year (1936) it was hoped to arrange a tour in Somerset and Devon. The Association Football Club had a prouder record, however, for they had won all their matches in the University of London League, the 1st XI had been narrowly defeated by St. Mary's in the final of the Hospitals Cup, and the 2nd XI had retained the Junior Cup.

Bad weather had been responsible for spoiling a great part of the Hockey Club's season, but they also were organizing a tour this year in the Ruhr district of Germany.

The reports from the secretaries of the Athletics, Boxing, Sailing, Golf, Lawn Tennis and Fives Clubs were read, reference was made to lectures delivered before the Abernethian Society and to the Christmas production of the Amateur Dramatic Society, and an account of the doings of the Rifle, Swimming and Fencing Clubs terminated the report.

Concluding, Mr. Mundy said: "Finally, Gentlemen, we wish the Students' Union every success in the coming year and beg to remain,

"Your obedient servants,
"R. MUNDY,
"R. HANBURY-WEBBER, Hon. Secs."

The following officers were elected for the coming year:

President	Dr. Roxburgh.
Vice-President	R. Mundy.
Secretary	R. Hanbury-Webber.
Junior Secretary	T. M. C. Roberts.
Financial Secretary	R. G. Gibson.
Treasurers	Dr. Wilfred Shaw. Prof. J. Paterson Ross.

The following gentlemen were elected to the Council of the Students' Union:—

Constituency A:

R. G. Gibson (Cambridge)	87 votes.
E. H. Hambly (London)	81 ,,
C. N. Bunham Slipper (London)	64 ,,
J. R. O. Thompson (Conjoint)	48 ,,
G. A. Richards (Conjoint)	43 ,,

Constituency B:

J. J. Slowe (London)	38 votes.
T. M. C. Roberts (Conjoint)	29 ,,

Constituency C:

J. H. West	unopposed.

The following are the results of Club fixtures held since the end of February:

Rugby XV	*v.* Moseley. *Lost*, 8–3. Semi-final Inter-Hospitals Cup *v.* St. Thomas's Hospital. *Lost*, 10–0. *v.* Rosslyn Park. *Won*, 8–5.
Rugby "A" XV	*v.* R.N.V.R. *Won*, 23–3. *v.* Old Millhillians "A". *Lost*, 9–3. Semi-final Inter-Hospitals Junior Cup *v.* London Hospital "A". *Won*, 3–0.
Association XI	Final Inter-Hospitals Cup *v.* St. Mary's Hospital. *Lost*, 4–3. *v.* St. John's Hall. *Won*, 10–0. *v.* Richmond College. *Won*, 4–0. League results to date: *Played* 9, *won* 8, *lost* 1.
Association 2nd XI	Final Inter-Hospitals Junior Cup *v.* St. Mary's Hospital 2nd XI. *Won*, 3–2.
Hockey XI	*v.* King's School, Canterbury. *Lost*, 6–2.
Hockey 2nd XI	Inter-Hospitals Junior Cup: 1st round *v.* St. Mary's Hospital 2nd XI. *Won*, 5–3. 2nd round *v.* London Hospital 2nd XI. *Won*, 8–0. Semi-final *v.* St. Thomas's Hospital 2nd XI. *Won*, 2–1.
Fencing	*v.* R.M.C. Sandhurst (3 F.S.). *Lost*, 12–6.

RUGBY FOOTBALL CLUB.

Semi-final Inter-Hospitals Cup.

ST. BARTHOLOMEW'S HOSPITAL *v.* ST. THOMAS'S HOSPITAL.

Played at Richmond. *Lost*, 10–0.

St. Bartholomew's Hospital met its Waterloo on the playing-fields of Richmond on the afternoon of March 5th. Although at the start play was even, there was only one period during the game when we really looked like scoring, and that came at the beginning of the second half when St. Thomas's had only three points, and penalty points at that, to their credit. Hopes ran high for a time, but were short-lived. They had obtained this lead just before half-time as the result of the marked tendency of our forwards to fall offside, and once more we cannot refrain from commenting on the nine free-kicks which were offered by our forwards to their opponents. They worked hard, but seemed somehow to lack co-ordination.

Luck was against us. Hearn got badly shaken up in the early stages of the game and his passing suffered in consequence; Youngman was hurt, too, and St. Thomas's had the benefit of a freshening wind in the second half—but such are only excuses. The three-quarter backs are indeed to be congratulated in that St. Thomas's never crossed our line, but at the same time there were only two or three movements of their own which might have borne fruit and their handling was not creditable. Fifteen minutes from the end another free kick from the '25 enabled Fenwick to increase the St. Thomas's lead, and victory was made sure by a fine goal dropped by Williams, the stand-off half.

As the secretary of the team remarked, it was rather a disappointing game.

Team.—C. R. Morison (*back*); E. Griffiths, R. I. G. Coupland, G. A. Fairlie-Clarke, J. G. Youngman (*three-quarters*); P. L. Candler, R. D. Hearn (*halves*); P. D. Swinstead, A. R. P. Ellis, E. M. Darmady, G. Gray, W. M. Capper, J. C. Newbold, R. Mundy, G. T. S. Williams (*forwards*).

ASSOCIATION FOOTBALL CLUB.

Inter-Hospitals Cup Final.

ST. BARTHOLOMEW'S HOSHITAL *v.* ST. MARY'S HOSPITAL.

Played at Kingston on March 5th against St. Mary's Hospital. *Lost*, 4–3.

Having beaten St. Thomas's in the Semi-final in a game that was more a test of endurance than a football match, the Club was very hopeful of winning the Senior Cup, but this was not to be. Looking back on the match it must be admitted that we were beaten by a better team, a team that would not give up when a goal down, but fought back all the time. They improved steadily, and in the last 20 minutes had the game well in hand. When St. Bartholomew's obtained the lead, which they did three times, there was a definite tendency to fall back on the defensive—a fatal mistake with fast moving and hard shooting forwards such as St. Mary's possess. One gained the impression that if the Mary's backs had been hustled and worried all through the game as they were in the first half they might well have broken down.

In our team, the man of the match was Knowles; his sure tackling and cool kicking was a pleasure to watch. Of the halves Coleman was best, and of the forwards Waring, though Ward on the other wing was also good and Gilbert was always in the fight. Waring opened the scoring after 15 minutes of throwing-in. Ward cut in from the left and from his pass Waring scored. Mary's at once equalized. After 35 minutes a corner from Ward was beautifully converted by Howell, but again Mary's equalized. Half-time, 2–2. Five minutes after half-time Ward centred to Gilbert, who was unmarked, and again Bart.'s had the lead. From then on St. Mary's attacked relentlessly, and scored two goals to win 4–3.

Team.—T. O. McKane; H. Knowles, P. J. Hardie; R. W. A. Coleman, D. R. S. Howell, J. L. Cardwell; J. W. B. Waring, P. A. K. Brownlees, R. G. Gilbert, J. O. Gallimore, A. I. Ward.

Inter-Hospitals Junior Cup Final.

ST. BARTHOLOMEW'S HOSPITAL *v.* ST. MARY'S HOSPITAL.

Won 3–2. St. Bartholomew's Hospital played well and deserved to win. For most of the game they were pressing, and the two goals scored by St. Mary's in the first half were due in part to the laxity of the defence, though this improved in the second half and they were never in real danger. James scored twice in the first half, once with his head and once with his foot, while the deciding goal was scored about 15 minutes after half-time by Grossmark with a very good shot. Wells-Cole, James and Owen deserve especial mention, with the rest of the team *prox. access.*

Team.—G. N. Wells-Cole; G. Herbert, J. P. McGladdery; G. H. Darke, R. M. Elder, K. B. Scott; C. A. Nicolson, W. A. Owen, A. Grossmark, C. J. A. James, B. H. Goodrich.

UNITED HOSPITALS BOXING COMPETITION.

The competition was held on March 3rd in the Stadium Club, Holborn, a great improvement on the familiar Blackfriars Ring, and the honours of the evening were divided between the London and St. Mary's Hospitals. The St. Bartholomew's team did not shine, but can fairly claim to have had more than its share of misfortune. Nevertheless, it is high time the Cup was back here again.

R. F. Boomla put up a very creditable performance in the fly-weights, and his quick straight left gained him many points against Griffiths of St. Thomas's. He was still within reach of victory in the third round when he stopped a couple of good rights from his opponent and the referee stopped the fight. T. P. Storey was up against J. E. Lovelock in the feather-weights, and a very fast fight resulted. Storey was elusive, and Lovelock, who eventually won his weight, found him hard to hit, but he lacks a good attacking punch. In the light-weight semi-final J. W. G. Evans found in B. Wilson of St. Thomas's an opponent who could assimilate plenty of punishment. At the end of the first round he had his man dazed on the ropes and might have finished him off, but he waited until the second round, when he knocked him out with a couple of vicious rights.

Bell boxed better against Evans of St. Mary's than we have seen him previously. He lost the second round, but maintained the aggression throughout the rest of the fight, and the decision of the judges against him was critically received. In the welter-weights J. J. Slowe, the Captain of the United Hospitals team, was not very impressive against Cohen of St. Mary's; he was clearly trying to save a damaged right hand, and it wasn't until the last round that he began to show us the class of boxer that he is and increase his lead to ensure a victory. A. Sandiford is to be complimented on knocking out Stevens of St. Mary's, an experienced South African boxer, in the semi-final of the heavy-weights. He scored well and often with his left hand against a difficult opponent, and when he gains more experience should develop into a very useful boxer.

Our hopes of having two champions to our credit were dashed when Slowe lost his fight with Rees of St. Thomas's, and Evans was knocked out by Holamandres of Guy's. Slowe's fight was a disappointment, but he was not at his best and the weakness of his right hand had undermined his confidence, though he scored many times with his left. He should not be discouraged, for he has the right to be proud of his year as Captain of the United Hospitals team, which culminated in a victory in the Inter-Hospitals and Universities Competition.

Evans *v.* Holamandres in the final of the light-weights promised to be the best fight of the evening. Towards the end of the first round we saw that Evans had ceased to use his left hand, and in the second round this injury—it turned out to be a Bennett's fracture—made it no longer possible for him to hold off his opponent and Holamandres took full advantage of this, knocking him out before the round was over.

CORRESPONDENCE.

PATHOLOGICAL REFUSE.

To the Editor, 'St. Bartholomew's Hospital Journal'.

SIR,—Still bearing the signature of the late Sir Frederick Andrewes is a notice by the door of the cold-storage room in this Department declaring, in the picturesque phraseology always at his command, that unlabelled material left there would periodically be "cast out and burned with fire". This warning is no less necessary at the present day than it was in his time. More often than not human remains of some kind have been discoverable there at any time for many years past, and the principal immediate cause of this letter is an amputated leg in an advanced stage of decay, contained in an immense brown paper bag, and bearing not the smallest clue to its

origin or ownership. This is only one among many specimens, chiefly of body fluids, which have rested in this room for long periods and lost all appearance of possessing usefulness or value.

Time stands still in a cold-storage chamber; things "stay put" in more than one sense, and forgetfulness encouraged by a perhaps not fully merited confidence in freedom from decay is excusable. But we are entitled to assume that after a certain lapse of time material can no longer be wanted, unless its ownership is declared and the owner can therefore be reminded of its presence. I have the authority of the Professor of Pathology in stating that for all unlabelled specimens the rule framed by Sir Frederick Andrewes will in future be enforced with greater regularity and severity than in the past.

I am,
Yours faithfully,
LAWRENCE P. GARROD.

Pathological Department,
St. Bartholomew's Hospital,
London, E.C. 1;
March 12th, 1936.

REVIEWS.

THE LIFE AND WORKS OF CHARLES BARRETT LOCKWOOD, by E. C. O. JEWESBURY, M.A., B.M.(Oxon), has now been published by H. K. Lewis & Co. Ltd. Price 3*s.* 6*d.*; cloth cover, 2*s.* 6*d.*

This appeared in our columns last year, and we cannot recommend it too highly to our readers.—ED.

THE EARLY DIAGNOSIS OF MALIGNANT DISEASE: FOR THE USE OF GENERAL PRACTITIONERS. By DONALDSON, CADE, HARMER, OGIER WARD, and TUDOR EDWARDS. (Oxford University Press. London: Humphrey Milford, 1936.) 8vo. Pp. viii + 168. Price 8*s.* 6*d.*

In spite of the irrepressible optimism of the Daily Press no "cancer cure" has ever yet come up to expectations, so that the importance of early diagnosis of the disease remains as great as ever. This is emphasized by the fact that we are now for the second time within a few months reviewing a book entitled *The Early Diagnosis of Malignant Disease*, and it is interesting to find that both volumes are the production of members of the staff of this hospital. Not that there is any rivalry between them. The book already reviewed was of small compass and cost but half-a-crown. The present volume has greater dignity and cubic content, and must contain a good many more words. Also it is written by five pens instead of one, and may therefore be supposed to be more comprehensive. The object of both books, as expressed by Dr. Malcolm Donaldson in his preface, is "to remind the general practitioner of the essential points in making a provisional diagnosis of cancer, and to urge the necessity of at once sending the patient to some hospital or other institution for expert opinion". Too often a provisional diagnosis results only in a period of delay before expert opinion and investigation is called in. This mistake the book now sponsored and partly written by Dr. Donaldson will certainly help to correct, if only it be read and digested by those who have the best opportunity of making early diagnoses—the general practitioners. Although the book has been compiled by five pens, the greater part of it has been written by one general surgeon, Mr. Stanford Cade of the Westminster Hospital staff. He has been assisted by four specialists—Dr. Donaldson, Mr. Douglas Harmer, Mr. Ogier Ward and Mr. Tudor Edwards—who have each contributed one section dealing with his speciality. The remaining eight sections are covered by Mr. Cade. As might be expected from the names of the writers, there is little to criticize in what they have written. The early signs and symptoms of cancer in all parts of the body are described as clearly as they can be, and the methods of investigation indicated. Mr. Cade and Mr. Harmer have long collaborated at the Mount Vernon Hospital in the treatment of malignant disease of the upper air-passages, and no one could speak with greater authority than does Mr. Harmer in the section assigned to him. Elsewhere occasional exaggerations of statement can be detected. For instance, in relation to bleeding from the nipple, "duct carcinoma is as frequent as duct papilloma" is perhaps an over-statement, but it is at any rate an emphasis in the right direction. In relation to the diagnosis of cancer of the gall-bladder, it is stated that "a clinical diagnosis of primary carcinoma is not always possible, particularly in its early stage". From the seven pages devoted to cancer of the bile-passages and pancreas it is abundantly clear that early diagnosis is *never* possible except by chance, and it may be doubted whether any light is shed by this section. The space might more profitably have been given to a discussion of the early diagnosis of carcinoma of the thyroid gland, which, surprisingly enough, has been completely omitted. It was inconsistent, in a work dealing with carcinoma in its various forms, to include a section on sarcoma of bone, though fully justifiable, since this is one of the few forms of sarcoma in which relatively early diagnosis is likely to be made.

The printing, as is usual with the Oxford medical books, is large and readable and the page well proportioned. The whole book is indeed worthy of the importance of its subject, and Dr. Donaldson is to be congratulated on the success of a venture which obviously took its inspiration from him.

SYNOPSIS OF SURGICAL ANATOMY. By ALEXANDER LEE MCGREGOR, M.Ch.(Edin.), F.R.C.S.(Eng.). Third edition. (Bristol: John Wright & Sons, Ltd., 1936.) Price 17*s.* 6*d.*

For those who like their anatomy potted this is the text-book *par excellence*, for there are few theories in it, and though grim facts only are included, they are presented in an orderly and logical fashion. The book is in two parts of equal length—the anatomy of the normal and the anatomy of the abnormal—but each chapter is an entity in itself, and can be read and, we hope, understood without reference to others. There are more pictures than pages, which should commend it to the tired student. The fact that a new edition is offered containing so few changes is sufficient evidence of the popularity of this book.

THE STORY OF THE MIDDLESEX HOSPITAL MEDICAL SCHOOL. By H. CAMPBELL THOMSON, M.D., F.R.C.P. (John Murray, 1935.) Price 10*s.* 6*d.*

There is romance enough in the daily happenings in a great modern hopsital, but for those who pause to consider, the evolution of such a place provides food for thought, and for a historian with a taste for research amongst forgotten archives and a devotion to his subject, such as Dr. Campbell Thomson possesses, there is material in plenty.

The link with the past, illustrated with many a quaint anecdote, which Dr. Thomson gives us, will serve not only to afford us yet another glimpse of the struggles of Medicine in its infancy—of times when truth must be sought out afresh and loosed from the smothering bonds of prejudice and superstition with which it was obscured. It also will record the progress which has been made in a short two hundred years, in building up the Middlesex Hospital of to-day, from the scanty beginnings provided by two small dwelling-houses endowed for the treatment of the sick and lame in 1745, at which time the country between the hospital and the City was the haunt of wild-fowl and highwaymen.

The book should be of especial interest to the medical student of to-day in convincing him of the happiness of his lot—so very different from what it was even a hundred years ago.

A FIRST COURSE IN HUMAN PHYSIOLOGY. By G. NORMAN MEACHEN, M.D., B.S. Second edition. (University Tutorial Press, 1936.) Price 3*s.* 6*d.*

The modern progressive trend of all science compels the frequent revision of the literature. This new edition contains many new sections, many more having been revised to incorporate the results of recent research.

However, the book remains one which is not of very great use to the medical student. Aiming at "a general introduction to the subject", it runs a course which may interest and be of some purpose to those who have just finished the preliminary science co-ordinating them with their future work.

The illustrations, which are very numerous, are good and clearly annotated. The questions at the end of each chapter are adequate, but the suggested practical work seems to us fatuous.

A MANUAL OF PHYSICS. By J. A. CROWTHER, Sc.D., F.Inst.P. Fourth edition. (Oxford University Press, 1936.) Price 14*s.*

Many clinical students will remember this excellent book in far distant days when they grappled with first M.B.'s and premedical conjoints. It is for the benefit of those pre-clinical students who

have not as yet discovered it that we give it our wholehearted blessing. It is still in its old form, but naturally enough, it has been brought up-to-date regarding X-rays, radio-activity and the more universal application of alternating current.

PRIVATE NURSING. By MARIANNE WENDEN, S.R.N., S.C.M. (Faber & Faber, Ltd., 1936.) Price 6*s*.

It is well that a nurse who, on completion of her general training, contemplates taking up private nursing, should have at her disposal information in a concise and readable form dealing specifically with that subject. This volume serves that purpose usefully. The early chapters deal with such points as the qualifications desirable, the various channels of employment, expenditure and possible income, and the equipment necessary, while the remainder of the book is devoted to practical details of nursing.

BELOVED GHOSTS. By "OLE MAN RIVER". (John Bale.) Price 6*s*.

This is a slight volume of somewhat sentimental anecdotes which may recall persons and scenes to those whose memories stretch back to the closing years of the last century. It might be better value if the price were less by half-a-crown.

We have also received:

SURGICAL INSTRUMENTS AND APPLIANCES USED IN OPERATIONS. By HAROLD BURROWS, C.B.E., M.B.(Lond.), B.S., F.R.C.S. New edition. (Faber & Faber, 1936.) Price 2*s*. 6*d*.

REMEDIAL EXERCISES FOR CERTAIN DISEASES OF THE HEART AND LUNGS. By HESTER S. ANGROVE. (Faber & Faber, 1936.) Price 6*s*.

DISEASES OF THE EAR, NOSE AND THROAT. By W. S. SYME, M.B., F.R.F.P.S. Catechism Series. Second edition. (E. & S. Livingstone, 1936.) Price 1*s*. 6*d*.

ORAL HYGIENE. By HARRY CAMPBELL, M.D., F.R.C.P. (Reprinted from *The Medical World*, January, 1936.) Price 6*d*.

Medical Publications, Ltd., inform us that the price of *Post-Graduate Surgery* (Maingot) has been raised to £3 10*s*. per volume, or £9 9*s*. per set of three volumes.

EXAMINATIONS, ETC.

University of Cambridge.

The following Degree has been conferred:

M.D.—Kersley, G. D.

University of London.

Second Examination for Medical Degrees, March, 1936.

Part I.—Akeroyd, G. A. S., Baldwyn, A. F., Birch, R. G., Bone, D. H., Boomla, R. F., Burkitt, E. A., Chisholm, J. K., Cocks, D., Dickson, R. R., Elek, S. D., Ezechiel, P. A., Fitzhardinge, A. N. B., Fry, P., Garden, J. F. G., Griffiths, E., Harold, J. T., Heathfield, K. W. G. G., Jamison, H. M., Karn, H., Katz, A., Latcham, P. R., Leven, M., Liberthson, A., McFarlane, M., Macpherson, R., Manning, J. D., Morris, O. D., O'Callaghan, M. D. M., Orchard, N. P., Pablot, P. J., Protheroe, B. A., Rees, E. H., Saudek, A. C. J., Scatliff, J. N. R., Simpson, R. A. H., Sutton, M. G., Walker, A. J., Ward, A. I., Wigglesworth, R., Williamson, D. A. J., Wohl, M.

British College of Obstetricians and Gynæcologists.

The following have been elected to the **Membership**:

Jeaffreson, B. L., MacVine, J. S.

CHANGES OF ADDRESS.

BALLINGALL, Lt.-Col. D. C. G., M.C., R.A.M.C., British Military Hospital, Nasirabad, Rajputana, India.
BEADLES, H. S., 20, Clevedon Mansions, Lissenden Gardens, N.W. 5.
BROCKLEHURST, R. J., 11, Avon Grove, Sneyd Park, Bristol 9.
ELLISON, P. O., 12, Wimpole Street, W. 1. (Tel. Langham 4260.)
KILLINGBACK, H. C., 50, Clarendon Court, Finchley Road, N.W. 11.
KING, Lt.-Col. H. H., C.I.E., I.M.S., Fairlawn, Beaconsfield, Bucks. (Tel. Beaconsfield 893.)
MACKENZIE, A. V., Belmont House, Shrewsbury.
OAKLEY, W. G., 14, Blenheim Road, St. John's Wood, N.W. 8. (Tel. Maida Vale 1281.)
WEST, C. ERNEST, The Hive, Sturminster Newton, Dorset.

APPOINTMENTS.

KING, J. F. LASCELLES, M.B., B.S.(Lond.), appointed Anæsthetist to the Evelina Hospital, Southwark.
OAKLEY, W. G., M.D., M.R.C.P., appointed Honorary Assistant Physician to St. Andrew's Hospital, Dollis Hill.

BIRTHS.

BELL.—On March 24th, 1936, at 19, Bentinck Street, to Hilda (*née* Faure), wife of Arthur C. Bell, F.R.C.S.—a daughter.
BOURNE.—On March 28th, 1936, to Joyce (*née* Postle), wife of Dr. W. A. Bourne, of 46, Wilbury Road, Hove—a daughter.
DAVENPORT.—On March 17th, 1936, at 27, Welbeck Street, to Helen (*née* Mayfield), wife of Robert Davenport, F.R.C.S.—twin sons.
DAY.—On March 14th, 1936, at Norwich, to Dr. and Mrs. George H. Day—a son.
EDWARDS.—On March 24th, 1936, to Betty (*née* Murdoch), wife of Dr. John A. Edwards, Coln Cottage, Colnbrook, Bucks—a son.
EVANS.—On March 8th, 1936, at Alfred House, Portland Place, W. 1, to Viola (*née* Quennell), wife of Frankis Evans—a son (Robert).
HIGGINSON.—On March 3rd, 1936, at Sussex House Nursing Home, W. 9, to Nora (*née* Rolfe), wife of H. C. H. Higginson, M.B.—a son.
KING.—On February 21st, 1936, at 32, Chepstow Place, W. 2, to Moira (*née* Atteridge), wife of J. F. Lascelles King—a son (David).
PAGAN.—On March 15th, 1936, at 104, St. James Road, Southampton, to Betty (*née* Watkins), wife of Dr. A. T. Pagan—a son.
WHITCHURCH HOWELL.—On March 11th, 1936, to Frances (*née* Roper Blackwood), wife of Bernard Whitchurch Howell, of 123, Harley Street, W. 1—a daughter.

MARRIAGES.

GROVES—ST. JOHN.—On March 28th, 1936, at St. Cross, Winchester, by the Bishop of Winchester, assisted by Rev. S. T. Percival, Dr. John Nixon Groves, son of Dr. and Mrs. C. Nixon Groves, to Myrtle St. John, niece of Sir Charles and Lady Close.
KNOX—CRUST.—On March 21st, 1936, at St. Bartholomew the Great, Dr. Robert Knox, of Cambridge, to Lynda Crust, of Miningsby.

DEATHS.

EDER.—On March 30th, 1936, passed peacefully away from heart failure after a short illness, at 6, Brendon House, W. 1, Dr. M. David Eder.
GARROD.—On March 28th, 1936, suddenly, at 1, Huntingdon Road, Cambridge, Archibald Edward Garrod, K.C.M.G., D.M., F.R.S., aged 78.
GIBBENS.—On March 1st, 1936, at 1, Bank Chambers, Barking, Frank Edward Gibbens, M.R.C.S., L.R.C.P.
SHADWELL.—On March 21st, 1936, at Richmond, Arthur Shadwell, M.D., F.R.C.P., husband of Alice Louise Shadwell, aged 81.
TWEEDIE.—On March 18th, 1936, Alexander Robert Tweedie, F.R.C.S., T.D., late Colonel R.A.M.C.

NOTICE.

All Communications, Articles, Letters, Notices, or Books for review should be forwarded, accompanied by the name of the sender, to the Editor, ST. BARTHOLOMEW'S HOSPITAL JOURNAL, *St. Bartholomew's Hospital, E.C.* 1.

The Annual Subscription to the Journal is 7*s*. 6*d*., *including postage. Subscriptions should be sent to the* MANAGER, Mr. G. J. WILLANS, M.B.E., B.A., *at the Hospital.*

All Communications, financial or otherwise, relative to Advertisements ONLY should be addressed to ADVERTISEMENT MANAGER, *The Journal Office, St. Bartholomew's Hospital, E.C.* 1. *Telephone: National* 4444.